PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	AID SERVICES	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G279	B. WIN			05/17	/2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIEF	R		227 E F	IIGH ST		
JAY-RAN	IDOLPH DEVELOF	PMENTAL SERVICES		PORTL	AND, IN 47371		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000000							
		or an annual fundamental	W0	00000			
	recertification as	nd state licensure survey.					
	Dates of Survey	: May 6, 7, 8 and 17,					
	2013.						
	Facility Number	r: 000799					
	Provider Numbe	er: 15G279					
	AIMS Number:	100249030					
	Surveyor: Vicki	e Kolh RN					
	Surveyor. Vicki	c Rolo, Riv					
	Thaga dafiaiamai	ies also reflect state					
	_	rdance with 460 IAC 9.					
		completed 5/30/13 by					
	Dotty Walton, Q	QIDP and Ruth					
	Shackelford, QI	DP.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000799

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/17/2013	
	ROVIDER OR SUPPLIER	MENTAL SERVICES	p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE HIGH ST AND, IN 47371	1	
(X4) ID PREFIX TAG W000149	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	STAFF TREATMITHE facility must of written policies are mistreatment, neg Based on record 1 of 4 sampled of additional clients the facility negle policy and proce allegations of negwere thoroughly reproducible system clients #4, #5, #6  Findings include  The facility's recto 5/6/13 at 1 PM.  _A 5/29/12 BD 5/27/12 at 6:25 Fecoming out of the was waiting to go [Client #7] hit [collect arm with the [Client #4] then put to the ground. [Continuity the back of floor." The facility indicate an investigation of the product of the ground of the ground of the ground. [Continuity the back of floor." The facility indicate an investigation of the ground of the ground of the ground of the ground of the ground. [Continuity the back of floor." The facility indicate an investigation of the ground of the gro		W0	00149	Now and in the future, all allegations of client to client aggression and incidents with potential of causing client harr will be investigated per the JR Individual Protection Policy. JRDS new staff and existing swill be trained regarding the JRDS Individual Protection Potente JRDS Procedures for Stat Reporting and the use of their reporting and investigation for upon hire and retrained, at leas annually. Residential Departmental Head, Home Manager, QMRF and DSPs responsible.	nDS taff blicy, e new m st, nent	06/11/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 2 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		15G279	B. WIN	G		05/17/	2013
	PROVIDER OR SUPPLIER	MENTAL SERVICES		227 E H	.ddress, city, state, zip code IIGH ST AND, IN 47371		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TF	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	getting her lunch	pail, but turned and					
	grabbed [client #	<sup>2</sup> 7] and scratched her					
	·	t indicated the staff					
	"found a 1/2 inch scratch on [client #7's] neck." The facility records did not indicate an investigation was conducted.						
	A 10/19/12 BDDS report indicated on						
	10/18/12 at 4:35 PM "[Client #5] began to obsess about a party that was occurring at day programming the next day [Client						
	#5] walked around the corner and smacked [client #7] on top of the head						
	open handed wit	h moderate force,					
	unprovoked." Th	ne facility records did not					
	indicate an inves	stigation was conducted.					
	A 11/15/12 B	DDS report indicated on					
		PM client #6 "lightly					
		5] on the arm [Client					
		out stopped when staff					
	1 1	at she was not hurt." The					
	facility records of	lid not indicate an					
	investigation wa	s conducted.					
	A 4/19/13 BD	DS (Bureau of					
		Disabilities Services)					
		on 4/18/13 at 2:35 PM					
	client #4 pushed						
	_	ort of 4/19/13 indicated					
		not fall - she lowered					
	-	ound and yelled, 'She					
		marks or redness resulted.					
	. ^	elient #4's] behavior plan					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 3 of 20

	NOF CORRECTION IDENTIFICATION NUMBER:  15G279	A. BUILDING	00	COMPL 05/17/	ETED
	130218	B. WING	DDEGG CVIIV CITY CITY CITY	03/17/	2010
	PROVIDER OR SUPPLIER  NDOLPH DEVELOPMENTAL SERVICES	227 E HIG	DRESS, CITY, STATE, ZIP CODE GH ST ND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	and separated the clients. Home manager felt [client #4] behaved impulsively due to her [client #4's] being attention seeking and feeling jealous (not wanting [client #7] to take staff attention from her)"  The investigative report did not indicate client interviews, interviews of all staff present at the time of the incident and/or record reviews conducted. The investigative record did not indicate a thorough investigation was conducted in regard to the client to client abuse on 4/18/13 for clients #4 and #7.  Interview with the Agency Department Head on 5/6/13 at 2 PM indicated all investigative records were provided for review.  Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 5/8/13 at 2 PM stated, "We are in the process of changing the way things are done, but I know it's too late to go back after the fact." The QIDP indicated all incidents of client to client abuse were to be thoroughly investigated.  Review of the revised facility policy "Individual Protection Policy" of 5/12 on 5/6/13 at 2 PM indicated "JRDS [Jay-Randolph Developmental Services] personnel are required to preserve an individual's rights, dignity, health, and				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 4 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279		A. BUILDIN		nstruction 00	(X3) DATE S COMPL 05/17/	ETED	
	PROVIDER OR SUPPLIE	R	2	27 E H	DDRESS, CITY, STATE, ZIP CODE IGH ST	00/11/	2010
(X4) ID	SUMMARY S	PMENTAL SERVICES  STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	REGULATORY OF	RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX AG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	COMPLETION DATE
	safety. As such neglect, exploita individual serve individual's right abuse to be the physical force s shoving, shaking acts actions, we commands, or of in a detrimental individual involutional derogatory state isolation, demeas calling, and other policy indicated not be subjected including, but nother consumers volunteers, staff the individual, finguardians, friend The facility polition report abuse/simmediately to a designee and to	JRDS prohibits the abuse, ation, mistreatment of an d or the violation of the its." The policy defines 'use of unreasonable uch as spanking, pinching, g and other punitive verbal statements or ther procedure that result outcome for the ved (i.e. tone of voice, ment, facial expressions, uning gestures, name er damaging acts.)." The "Individuals served must to abuse by anyone, ot limited to, JRDS staff,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 5 of 20

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  DATE  W000154 483.420(d)(3)  STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.		IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SI	
NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES  JAY-RANDOLPH DEVELOPMENTAL SERVICES  STREET ADDRESS, CITY, STATE, ZIP CODE 227 E HIGH ST PORTLAND, IN 47371  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W000154  483.420(d)(3)  STREET ADDRESS, CITY, STATE, ZIP CODE 227 E HIGH ST PORTLAND, IN 47371  IN 47371  REGULATORY OR LSC IDENTIFYING INFORMATION)  AS 420(d)(3)  STREET ADDRESS, CITY, STATE, ZIP CODE 227 E HIGH ST PORTLAND, IN 47371  IN 47371  REGULATORY OR LSC IDENTIFYING INFORMATION)  AS 43.420(d)(3)  The facility must have evidence that all alleged violations are thoroughly investigated.  Based on interview and record review for 7-7 of 7 incidents of client to client abuse, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted for clients #4, #5, #6 and #7.  Findings include:  The facility's records were reviewed on 5/6/13 at 1 PM. A 5/29/12 BDDS report indicated on 5/27/12 at 6:25 PM "[Client #7] was waiting to go in to use the restroom. [Client #7] hit [client #4] on her upper left arm with the outside of her forearm. [Client #7] hit [client #4] on her upper left arm with the outside of her forearm. [Client #7] hit [client #7] down to the ground. [Client #7] down to the ground. [Client #7] left to the floor hitting the back of her right arm onto the floor." The facility records did not indicate an investigation was conducted.	AND PLAN	OF CORRECTION		A. BUIL	DING	00		
AST   AST			15G279				05/17/2	2013
JAY-RANDOLPH DEVELOPMENTAL SERVICES   PORTLAND, IN 47371	NAME OF P	PROVIDER OR SUPPLIER		•				
PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	JAY-RAN	IDOLPH DEVELOP	MENTAL SERVICES					
TAG  REGULATORY OR I.SC IDENTIFYING INFORMATION)  W000154  483.420(d)(3)  STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.  Based on interview and record review for 7 of 7 incidents of client to client abuse, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted for clients #4, #5, #6 and #7.  Findings include:  The facility's records were reviewed on 5/6/13 at 1 PM. A 5/29/12 BDDS report indicated on 5/27/12 at 6:25 PM "[Client #7] was coming out of the bathroom, as [client #4] was waiting to go in to use the restroom. [Client #7] hit [client #4] then pushed [client #7] down to the ground. [Client #7] fell to the floor hitting the back of her right arm onto the floor." The facility records did not indicate an investigation was conducted.  TAG  CROSS-REPERNOED TO THE APPROPRIATE  DATE  **COROS-REPERNOED TO THE APPROPRIATE  **DATE  **DATE  **OCOS-REPERNOED TO THE APPROPRIATE  **DATE  **OCOS-REPERNOED TO THE APPROPRIATE  **DATE  **OCOS-REPERNOED TO THE APPROPRIATE  **OCOS-REPERNOED TO T	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
W000154  483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 7 of 7 incidents of client to client abuse, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted for clients #4, #5, #6 and #7.  Findings include:  The facility's records were reviewed on 5/6/13 at 1 PM.  _A 5/29/12 BDDS report indicated on 5/27/12 at 6:25 PM "[Client #7] was coming out of the bathroom, as [client #4] was waiting to go in to use the restroom. [Client #7] hit [client #4] on her upper left arm with the outside of her forcarm. [Client #4] then pushed [client #7] down to the ground. [Client #7] fell to the floor hitting the back of her right arm onto the floor." The facility records did not indicate an investigation was conducted.		`			CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION
STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.  Based on interview and record review for 7 of 7 incidents of client to client abuse, the facility failed to provide evidence of an investigation and/or evidence a thorough investigation was conducted for clients #4, #5, #6 and #7.  Findings include:  The facility's records were reviewed on 5/6/13 at 1 PM.  _A 5/29/12 BDDS report indicated on 5/27/12 at 6:25 PM "[Client #7] was coming out of the bathroom, as [client #4] was waiting to go in to use the restroom. [Client #7] hit [client #4] on her upper left arm with the outside of her forearm. [Client #4] then pushed [client #7] down to the ground. [Client #7] fell to the floor hitting the back of her right arm onto the floor." The facility records did not indicate an investigation was conducted.  W000154  W000154  Now, and in the future, the attached form will be used to document the specifics of the investigation of incidents with potential to cause  client harm; as well as injuries of unknown source and neglect. All staff have been trained on how to use the form to collect information for the investigation.  Residential Department Head, Home Manager, QMRP and DSPs responsible.  SPs responsible.			LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
6/11/12 at 8:15 AM "When [client #6] came out of her room, it appeared she was getting her lunch pail, but turned and grabbed [client #7] and scratched her neck." The report indicated the staff	W000154	STAFF TREATMITHE facility must be alleged violations investigated.  Based on interview of 7 incidents of the facility failed an investigation of thorough investigation of thorough investigation of thorough investigation of thorough investigation of the facility's recent of 5/6/13 at 1 PM.  A 5/29/12 BD 5/27/12 at 6:25 Fe coming out of the was waiting to go [Client #7] hit [coleft arm with the [Client #4] then put to the ground. [Coleft arm with the [Client #4] then put to the ground. [Coleft arm with the [Client #4] then put to the ground. [Coleft arm with the	have evidence that all are thoroughly  ew and record review for of client to client abuse, I to provide evidence of and/or evidence a gation was conducted for 5 and #7.  DS report indicated on PM "[Client #7] was to bathroom, as [client #4] to in to use the restroom. Client #4] on her upper outside of her forearm. Pushed [client #7] down Client #7] fell to the floor of her right arm onto the try records did not attigation was conducted.  DS report indicated on AM "When [client #6] room, it appeared she was a pail, but turned and for and scratched her	Woo	00154	attached form will be used to document the specifics of the investigation of incidents/allegations of incidents of client to client abuse and incidents with potential to cause client harm; as well as injuries unknown source and neglect, staff have been trained on how use the form to collect information for the investigation.  Residential Department Head Home Manager, QMRP and	nts se s of All w to	06/11/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 6 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G279	B. WING		05/17/2013
NAME OF F	PROVIDER OR SUPPLIER	\ \		ADDRESS, CITY, STATE, ZIP CODE	
		MENTAL SEDVICES		IIGH ST AND, IN 47371	
		MENTAL SERVICES		AND, IN 4737 I	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
1710		h scratch on [client #7's]	1710	·	DATE
		ty records did not			
		stigation was conducted.			
	indicate an inves	singation was conducted.			
	A 10/19/12 BI	DDS report indicated on			
	l <del></del>	PM "[Client #5] began to			
	obsess about a party that was occurring at day programming the next day [Client				
		nd the corner and			
	smacked [client #7] on top of the head open handed with moderate force,				
	unprovoked." The facility records did not indicate an investigation was conducted.				
		8			
	A 11/15/12 Bl	DDS report indicated on			
		PM client #6 "lightly			
		5] on the arm [Client			
		out stopped when staff			
	reassured her tha	at she was not hurt." The			
	facility records d	lid not indicate an			
	investigation wa	s conducted.			
	A 4/19/13 BD	DS (Bureau of			
	Developmental I	Disabilities Services)			
	report indicated	on 4/18/13 at 2:35 PM			
	client #4 pushed	client #7. The			
	investigative rep	ort of 4/19/13 indicated			
	"[Client #4] did	not fall - she lowered			
	herself to the ground and yelled, 'She pushed me!' No marks or redness resulted.				
	Staff followed [c	elient #4's] behavior plan			
	and separated the	e clients. Home manager			
	felt [client #4] be	ehaved impulsively due			
	to her [client #4's	s] being attention seeking			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 7 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  15G279	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 05/17/2013				
	PROVIDER OR SUPPLIER  NDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE  227 E HIGH ST  PORTLAND, IN 47371						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION				
	and feeling jealous (not wanting [client #7] to take staff attention from her)"  The investigative report did not indicate client interviews, interviews of all staff present at the time of the incident and/or record reviews conducted. The investigative record did not indicate a thorough investigation was conducted in regard to the client to client abuse of 4/18/13 for clients #4 and #7.  Interview with the Agency Department Head on 5/6/13 at 2 PM indicated all investigative records were provided for review.  Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 5/8/13 at 2 PM stated, "We are in the process of changing the way things are done, but I know it's too late to go back after the fact." The QIDP indicated all incidents of client to client abuse were to be thoroughly investigated.  9-3-2(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 8 of 20

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G279	B. WIN			05/17/	2013
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HIGH ST		
JAY-RAN	IDOLPH DEVELOP	MENTAL SERVICES			AND, IN 47371		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
W000220	483.440(c)(3)(v) INDIVIDUAL PRO The comprehensis must include spec development. Based on observer record review for (#3), the facility in regard to her or and/or needs.  Findings include  During observation of 5/6/13 between 63/7/13 between 63/7/13 between 63/7/13 between 63/7/13 between 63/14 was different #3 was different #3 was different stated "She [client understand at time."  Client #3's record at 1 PM. Client #4 (Comprehensive of 3/12 indicated assistance to continuous Client #3's ISP (1/2) of 9/25/12 contained the state of t	DGRAM PLAN ive functional assessment ech and language ation, interview and r 1 of 4 sample clients failed to assess the client communication skills  it is is at the group home on 3:30 PM and 6 PM and on 3:30 AM and 8 AM, ficult to understand. The to assist in with client #3. Staff #2 int #3] is difficult to ines."  d was reviewed on 5/7/13 #3's CFA Functional Assessment) I client #3 needed staff ivey wants and/or needs. Individual Support Plan ained no information onal speech/language  ine QIDP (Qualified bilities Professional) on	W0	00220	Now and in the future, all clien will be assessed in regard to the communication skills and or needs, at least annually; or as needed. The attached assessment will assist in determining the clients' need. The assessment determines the need for direct professional therapy, such therapy will be pursued. This annual date of the professional therapy will be documented/recorded on the Monthly Nursing Notes. Home Manager and Healthcare Coordinator responsible.	neir If e	06/11/2013
	5/8/13 at 2 PM s	tated client #3 had not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet Page 9 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G279	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM 	TE SURVEY  IPLETED  17/2013			
		MENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE  227 E HIGH ST  PORTLAND, IN 47371						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			
	_	guage evaluation to nmunication needs "To							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 10 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279		(X2) MI A. BUII		onstruction 00	(X3) DATE S	ETED	
		15G279	B. WIN	G		05/17/	2013
	ROVIDER OR SUPPLIER	MENTAL SERVICES		227 E H	ADDRESS, CITY, STATE, ZIP CODE HIGH ST AND, IN 47371		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W000242	for those clients we personal skills es independence (in toilet training, per hygiene, self-feed grooming, and coneeds), until it hat the client is devel acquiring them.  Based on record 3 of 4 sampled colients' ISPs (Indialed to address).  Client #2's ideregard to bathing care, tooth brush Client #3's ideregard to bathing care, tooth brush care, tooth brush fregard to bathing care, tooth brush fregard to bathing care, tooth brush care, tooth brush fregard to bathing care, tooth brush fregard to bathing dressing, tooth be toileting.  Findings include Client #2's record at 11 AM. Client (Comprehensive of 8/26/12 indicates assistance with be hair care, tooth be contacted to the contacted assistance with be hair care, tooth be contacted to the con	ogram plan must include, who lack them, training in sential for privacy and cluding, but not limited to, sonal hygiene, dental ding, bathing, dressing, mmunication of basic is been demonstrated that opmentally incapable of review and interview for dients (#2, #3 and #4), the dividual Support Plans) is sentified training needs in ing, personal hygiene, hair ing, privacy and toileting. Intified training needs in ing, personal hygiene, hair ing and toileting. Intified training needs in ing, personal hygiene, antified training needs in ing, personal hygiene, rushing, privacy and	W0	00242	Now, and in the future, all clien will be assessed and trained in personal skills essential for privacy and independence. Gwill be established and implemented re the personal skills that a client may be lack. These goals will be pursued u it has been demonstrated that client is developmentally incapable of acquiring them. It least annually the attached assessment will be reviewed to the QMRP and Home Manage ensure all personal skill areas need of training are being addressed with formal goals written and implemented. How Manager and DSPs responsibility for implementation. QMRP with monitor on a monthly basis.	oals ing. ntil the At by er to in	06/07/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 11 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279		A. BUILDING  B. WING			COMPLETED 05/17/2013		
		130273	B. WIN			03/17/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
JAY-RAN	IDOLPH DEVELOP	MENTAL SERVICES			IIGH ST AND, IN 47371		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	ers to use toilet paper					
	-	not always close the					
		Client #2's ISP dated					
	9/26/12 did not indicate any objectives to						
	assist client #2 in	regard to bathing,					
	personal hygiene, hair care, tooth						
	brushing, privacy and toileting.						
	Client #3's record	d was reviewed on 5/7/13					
	at 1 PM. Client #3's CFA of 8/30/12						
	indicated client #3 required assistance						
	with bathing, per	sonal hygiene, hair care,					
	tooth brushing ar	nd toileting. The CFA					
	indicated client #	<sup>4</sup> 3 required reminders to					
	use toilet paper a	nd assistance to clean					
	herself after havi	ng a bowel movement.					
		ated 9/25/12 did not					
	indicate any obje	ectives to assist client #3					
		ing, personal hygiene,					
	_	rushing and toileting.					
	,						
	Client #4's record	d was reviewed on 5/7/13					
		<sup>2</sup> 4's CFA of 8/27/12					
		4 required assistance					
		sonal hygiene, dressing,					
	- · ·	rivacy and toileting. The					
	CFA indicated cl						
		toilet paper and to close					
		acy. Client #4's ISP dated					
	_	ndicate any objectives to					
		regard to bathing,					
		tooth brushing, privacy					
		, wour orusining, privacy					
	and toileting.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet Page 12 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279		A. BUII	LDING	00	COMPL 05/17/	ETED		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		227 E HIGH ST					
	IDOLPH DEVELOP	MENTAL SERVICES			AND, IN 47371			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
TAG	During interview			IAG			DATE	
		ectual Disabilities						
	Professional) and							
	,	/13 at 2 PM, the HM						
		#2, #3 and #4 were not						
		required staff reminders						
	_	g, personal hygiene,						
		n brushing. The QIDP						
		#2, #3 and #4 did not						
		ectives in place to assist						
		pathing, personal hygiene,						
		nd toileting. The QIDP						
	indicated clients	#2 and #3 did not have						
	training objective	es in place to assist the						
	clients with hair	care, clients #2 and #4						
	did not have train	ning objectives in place						
	to assist the clien	its with privacy and client						
	#4 did not have a	any training objectives to						
	assist the client v	vith dressing skills.						
	9-3-4(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet Page 13 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COM			COMPLETED	
		15G279	B. WING			05/17/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					HIGH ST	
JAY-RAN	IDOLPH DEVELOP	MENTAL SERVICES			AND, IN 47371	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	REGULATORY OR  483.450(e)(2) DRUG USAGE Drugs used for combehavior must be part of the client's that is directed spreduction of and embehaviors for which Based on record 2 of 3 sampled commedications to complete the first of reduction the reduce and event behaviors for which psychoactive membehaviors for which psycho	ontrol of inappropriate used only as an integral individual program plan becifically towards the eventual elimination of the ch the drugs are employed. review and interview for lients receiving ontrol behaviors (#3 and failed to implement a plan clients could achieve to tually eliminate the nich the clients received dications.  ::  d was reviewed on 5/7/13 #3's physician's orders of d client #3 took Cogentin s) for involuntary	W0		Now, and in the future, all residents' behavior plans will include reduction of targeted inappropriate behaviors in correlation to the planned reduction of the behaviorally-specific, psychoactive prescrib medication. Documentation of realistic and achievable goat to warrant reduction of the medication (considering frequency and intensity) for reducing behaviors will be tracked based upon past-documented behaviors the determined the need for medications in the first place. Behavioral tracking will be documented by direct care state the Home Manager, and Day Programs; and tracking will be monitored monthly by the QMF Healthcare Coordinator, and F The HRC and Mental Health Provider will monitor at least quarterly or as changes dictated.	ed ls at

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet Page 14 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONS	00	(X3) DATE SURVEY  COMPLETED
	15G279	A. BUILDING B. WING		05/17/2013
	PROVIDER OR SUPPLIER  NDOLPH DEVELOPMENTAL SERVICES	STREET ADD	ORESS, CITY, STATE, ZIP CODE SH ST ND, IN 47371	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Client #4's record was reviewed on 5/7/13 at 2 PM. Client #4's physician's orders of 2/18/13 indicated client #4 took Paxil 20 mg for Impulse Control Disorder. Client #4's BSP of 9/25/12 indicated targeted behaviors of verbally teasing, accusing others falsely and physical aggression. Client #4's BSP indicated "If there are zero incidents of physical aggression and verbal teasing for a twelve month period, the physician involved will be consulted about a medication reduction."  Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 5/8/13 at 2 PM indicated she had been the one that had written the clients' behavior reduction plans and stated client #3's and #4's criteria for reduction "might be a bit much to expect" and needed to be reviewed and revised.  9-3-5(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 15 of 20

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  OF CORRECTION IDENTIFICATION NUMBER:  15G279	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/17/2013
NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES		STREET . 227 E H	ADDRESS, CITY, STATE, ZIP CODE HIGH ST AND, IN 47371	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000313	A83.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.  Based on record review and interview for 3 of 4 sampled clients (#1, #3 and #4) with medications prescribed to control maladaptive behaviors, the IDT (Interdisciplinary Team) failed to conduct a review of the risks of taking the medications as compared to the risks of the behaviors.  Findings include:  Client #1's record was reviewed on 5/7/13 at 10 AM. Client #1's physician's orders of 2/18/13 indicated client #1 took Prozac 40 mg (milligrams) and Wellbutrin 150 mg a day for anxiety and depression.  Client #1's BSP (Behavior Support Plan) of 9/26/12 indicated "a historical diagnosis of clinical depression, which can exhibit itself through symptoms of irritability, fatigue, feeling down, sleep problems, and anxiety." The client's record did not indicate the IDT had reviewed the risks of taking the medications as compared to the risks of the behaviors.  Client #3's record was reviewed on 5/7/13	W000313	Now, and in the future, all residents' behavior plans will include the risks of harmful effects from taking the medications used to control behaviors. At least annually the IDT will review the risk of taking the medications versus the risk the past or potential behaviors that have/may occur without the medication. QMRP is responsible; Healthcare Coordinator, RN will monitor monthly, HRC and the Mental Health Provider will monitor progress quarterly or as chandicate.	ng sk of s he

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 16 of 20

AND PLAN OF CORRECTION  XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G279			LDING	NSTRUCTION  00	(X3) DATE COMPL 05/17/	ETED	
NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES			p. WIIV	STREET A 227 E H	DDRESS, CITY, STATE, ZIP CODE IGH ST AND, IN 47371	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	2/18/13 indicated 5 mg for involunt Lithium 900 mg Bi-polar disorder aggression. Client indicated targete aggression, wand hallucinations. Tindicate the IDT taking the medic risks of the behat Client #4's record at 2 PM. Client #2/18/13 indicated mg for Impulse 0 #4's BSP of 9/25 behaviors of vertothers falsely and The client's record IDT had reviewed medications as as the behaviors.  Interview with the Intellectual Disates 5/8/13 at 2 PM indocumentation the client #1's, #3's at 12 PM in the client #1's, #3's a	the client's record did not had reviewed the risks of ations as compared to the viors.  d was reviewed on 5/7/13 the state of the viors.  d was reviewed on 5/7/13 the state of the viors of the client the state of the viore of the client the state of the risks of taking the compared to the risks of taking the compared to the risks of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 17 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G279		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP	LETED 7/2013
NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES			227 E F	ADDRESS, CITY, STATE, ZIP HIGH ST AND, IN 47371	P CODE	
	SUMMARY S (EACH DEFICIEN		227 E F	HIGH ST	ORRECTION N SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		15G279	B. WIN			05/17/2	013	
NAME OF D	DOWNER OF GUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			227 E F	HIGH ST			
		MENTAL SERVICES		PORTL	AND, IN 47371			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	+	DATE	
W000316	483.450(e)(4)(ii) DRUG USAGE							
		ontrol of inappropriate						
		gradually withdrawn at						
	least annually.							
	Based on record	review and interview for	W0	00316	Now, and in the future, all		06/13/2013	
	1 of 3 sample cli	ents receiving			residents receiving behavior			
	medications to co	ontrol maladaptive			controlling medications will be evaluated for a medication	;		
	behaviors (#3), t	he facility failed to			reduction unless contraindicate	<sub>ed:</sub>	e all	
	provide evidence	e an annual medication			specific contraindications will be			
	reduction had be	en attempted or specific			listed from collected data from			
	contraindications	s as to why an attempt			programming areas as to why			
	was not made.	attempt was not made. C	attempt was not made. QMRF and Home Manager	<b>,</b>				
					responsible/under the guidanc	e l		
	Findings include	·			and recommendations of the II			
	i mamas maraa	•			and the Mental Health Provide			
	Client #3's record	d was reviewed on 5/7/13			Healthcare Coordinator, RN w			
		#3's physician's orders of			monitor monthly and HRC and the Mental Health Provider will			
		d client #3 took Cogentin			monitor quarterly.	'		
		atary movements, Lithium						
	_	zo-Affective Bi-polar						
	_	orexa 10 for aggression.						
	3.1	00						
	Client #3's BSP of 9/25/12 indicated client #3 had targeted behaviors of verbal aggression and hallucinations. Review of							
		ior data sheets for						
		ry and March 2013						
		viors of verbal aggression						
		tions. Client #3's Medical						
	Appointment forms of 4/17/13, 1/17/13,							
		5/12 indicated client #3						
		no recommendations for						
		ges. Client #3's record						
		nges in client #3's						
	medications sinc	e 2005. Client #3's record						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet

Page 19 of 20

PRINTED: 06/27/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G279		A. BUII	05/17/2013			ETED	
		150279	B. WIN			03/17/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
JAY-RAN	IDOLPH DEVELOP	MENTAL SERVICES		227 E H PORTL	IIGH ST AND, IN 47371		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ual attempt of medication					
	reduction and/or	-					
	contraindications	s as to why an attempt					
	was not made.						
	Interview with th	ne QIDP (Qualified					
		bilities Professional) on					
		tated client #3 "rarely has					
		QIDP indicated the last					
		ration reduction for client					
	_	"and it did not go well."					
	·	the doctor did not					
	7	l reduction of client #3's					
		ad discontinued the					
		on completely, "causing					
		e a major increase in					
	behaviors."						
	9-3-5(a)						
	)-3-3(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7S3J11

Facility ID: 000799

If continuation sheet Page 20 of 20